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Integrating Management Performance Systems into an acquired business, focusing on the tensions it manages from a cultural perspective

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Abstract

This study examines how formal performance controls interact with the informal culture of a veterinary clinic after its acquisition by a corporate group. Busco et al.'s (2008) structural-tensions framework and Dent's (1991) cultural lens are used to analyze this post-acquisition integration. In the immediate aftermath, strong vertical oversight with imposed metrics and standardized procedures lead to intensified classic tensions. These reactions underscore Dent's (1991) insight that controls imposed without shared meaning provoke resistance. This study's findings integrate Busco et al.'s (2008) and Dent's (1991) perspectives, showing that post-acquisition control systems operate as an "integrated package" of formal and cultural controls. Successful integration requires aligning corporate performance metrics and profit-oriented ethos with the clinic's professional values. Tensions between vertical vs. lateral, convergence vs. differentiation, and centralization vs. decentralization often remained resolved rather than managed. By highlighting how the employee's identity and subcultures shaped outcomes, this study provides a nuanced understanding of tensions from a cultural perspective effect of tensions.

Keywords: Performance Management Systems; Post-Acquisition Integration; Technocratic Control; Socio-Ideological Control; Organizational Tensions; Veterinary Industry

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1. Introduction

1.1 Background

The veterinary services industry has experienced a complete change in organisational structure as a result of acquisitions in recent years, with corporate groups acquiring formerly independent clinics to create value through scale and efficiency. Independent Vetcare (IVC) an acquiring corporate group, is backed by the Swedish private equity firm EQT, is at the forefront of these acquisitions. In these clinics' pre-acquisition state, many were owner-operated by veterinarians and functioned as a tight knit, community-oriented clinic. Performance was inherently tied to personal reputation, customer-focus, and the owner-veterinarians often managed the business with a serviced and experience-based approach. Few had exposure to formal corporate management techniques, yet the alignment between clinical excellence and financial viability was maintained through the professionals' personal stake in the clinic's success.

Following IVC's acquisition of these clinics, the formerly independent clinics were merged into individual business units sat within a larger corporate structure. The new parent company introduced a range of technocratic controls – formalized systems for planning, budgeting, and performance measurement – to standardize operations and enforce group-wide financial discipline. Simultaneously, IVC attempted to instill its own socio-ideological controls, promoting a set of corporate values and cultural norms intended to unify employees under the IVC ethos. This marked a profound shift from an owner-driven management style to a corporate-managed model. While some operational independence was maintained for practicality, decisions that had once been made informally by the clinic's partners now required adherence to corporate policies and approval hierarchies and procedures.

The ongoing consolidation of veterinary clinics under corporate ownership—exemplified by IVC's expansion—has introduced profound changes for formerly independent veterinary practices. While such acquisitions are often justified by promises of greater efficiency, expanded resources, and shared services, the implementation of formal (technocratic) controls and cultural (socio-ideological) controls can produce significant

disruption at the local level. New performance metrics, standardized reporting structures, and capital-market pressures has shown to run counter to longstanding clinic values such as personalized client care and autonomous clinical decision-making. In the IVC case, the acquired equine clinic's staff suddenly had to answer to corporate Key Performance Indicators (KPIs) and procedures that did not necessarily align with their established ways of working as shown by Ahrens and Chapman (2004) and Carlsson-Wall et al. (2019).

As a result, clinic employees and managers found themselves navigating tensions in their day-to-day work. These include tensions between vertical vs. lateral relations (headquarters-imposed rules versus peer-to-peer collaboration), between convergence vs. differentiation of practices (one-size-fits-all policies versus local customization), and between centralization vs. decentralization of decision-making (top-down control versus local autonomy). Such tensions have been identified in prior research on integrating organizations globally by Busco et al. (2008) and Quattrone and Hopper (2005), but their manifestation in the veterinary clinic context raises specific lines of questioning. Equine clinics feature highly personalized client relationships, specialized treatment protocols, and staff whose professional identity is tied closely to patient welfare. The introduction of corporate controls in this context means that the clinics' socio-ideological norms—rooted in culture through personal relationships and professional autonomy—are now expected to meet technocratic directives aimed at uniformity, financial performance, and accountability.

This thesis explores the issues that arise from the traditional equine clinical practice and common reactions to the introduction of performance management systems, thus far triggered by corporate acquisitions. There is a need to understand how an equine veterinary clinic experiences and responds to an imposed corporate management control structure with its own legacy culture. By examining how the tensions manifest, evolve, and are negotiated in the wake of an acquisition, this study looks to deepen knowledge of how professional service organizations can be integrated seamlessly into corporate groups. The purpose of this thesis is to ask whether the push for efficiency and

profitability in a newly acquired clinic come at the cost of morale, identity, and service quality – and if so, how do employees and managers adapt to, or resist these changes?

1.2 Research Question

Using IVC's acquisition as a case study this thesis will focus on one main question: How has the implementation of performance management systems following an acquisition affected the organizational tensions from a cultural perspective within a veterinary clinic?

2. Theory and Literature review

2.1 Domain theory

Traditionally, Performance Management Systems (PMS) have been employed as integrative devices to mitigate global-local tensions. They provide a common language of metrics that can link subsidiary performance to corporate strategy which has been shown by Kaplan and Norton (1996). For example, a PMS might translate broad strategic goals into KPIs for each clinic, to ensure everyone works toward the same objectives as described in Ahrens and Chapman (2004). Illustrate that PMS use can foster both flexibility and efficiency – local managers might adapt performance metrics to fit their circumstances (using the system flexibly) while still adhering to overarching standards that enable comparison and control. Henri (2006) similarly finds that management control systems can encourage organizational learning at the local level, even as they align units with top-level strategy. These perspectives suggest that if implemented thoughtfully, technocratic controls need not be purely restrictive; they can provide frameworks within which local innovation occurs. However, Abernethy and Brownell (1999) caution that formal controls like budgets can also hinder responsiveness, especially in times of change, if they lock managers into rigid targets. Thus, whether technocratic controls enable or constrain depends on how they are designed and used. Research has found that these controls can influence and manage different tensions, which is the focus of this study. Busco et al. (2008) identify three key tensions that organizations can manage

through such integration, and they establish an effect between the integration of PMS and on these three identified tensions. These tensions are:

1. Vertical vs. Lateral Relations: This tension is between top-down, hierarchical control (vertical relations) and horizontal, peer-level coordination (lateral relations). In an acquisition, the corporate headquarters typically seeks to impose vertical controls – ensuring the acquired unit reports up through clear channels and follows central directives. At the same time, potential synergies of the acquisition (knowledge sharing, resource pooling) depend on fostering lateral relations between the acquired unit and other peer units or clinics. If vertical control is emphasized to the exclusion of lateral support, the acquired unit may feel isolated rather than part of a larger team as described by Busco et al. (2008) and Chenhall et al. (2013). Conversely, strong lateral networks can help mitigate the alienating effects of top-down mandates.

2. Convergence vs. Differentiation of Practices: Post-acquisition, the acquirer often pushes for convergence – standardizing processes across units for consistency and efficiency. However, each unit has differentiated practices tailored to its local context. Complete convergence can stifle valuable local innovations or reduce the unit's effectiveness if local conditions demand a different approach, described by Granlund (2003). Allowing some differentiation enables units to adapt practices to fit local client needs or operational realities. The challenge is to determine which practices must be uniform and where variability is acceptable which Smith and Lewis (2011) shown. Effective integration usually requires continually balancing these opposing pulls.

3. Centralization vs. Decentralization of Decision-Making: Acquisitions often shift decision authority toward the center for strategic control – budgets, major investments, and policies might now be decided by headquarters (centralization).

> While centralization can ensure alignment with corporate strategy and prevent certain decisions, it can also ignore on-the-ground insight and erode local empowerment, described by Simons (1995) as well as Malmi and Brown (2008). Decentralization, by contrast, entrusts local managers with autonomy to make decisions suited to their context, preserving agility and ownership at the unit levels. Finding the right degree of centralization is crucial: too much can demotivate or result in poor-fit decisions, while too little can fail to realize the benefits of being part of a larger organization.

Busco et al. (2008) showed that these tensions are interdependent and must be managed simultaneously, rather than addressed in isolation. Crucially, the aim is to obtain "the benefits of global coordination and the advantages of local responsiveness" a clear articulation of the overarching paradox facing post-acquisition integrations Busco et al. (2008, p. 7). Subsequent research has reinforced this view using paradox theory, which urges a "both/and" approach to such competing demands. Rather than resolving tensions by favoring one side (e.g. either complete centralization or complete decentralization), paradox theory suggests embracing and strategically balancing the poles over time. For instance, recent management accounting studies adopt a paradox perspective to examine how control systems can simultaneously enable control and flexibility. Strauss et al. (2025), in a case of a newly acquired division, find that individual control mechanisms often embed internal paradoxes (e.g. a performance metric that drives global consistency yet allows local adaptation) and that recognizing these paradoxes can help managers handle tensions better. This insight aligns with Busco et al.'s (2008) notion that integration is not the antonym of differentiation – both must co-exist in a dynamic balance.

2.2 Method theory

Dent's (1991) cultural perspective offers a theoretical lens to analyze how the effect of PMS on organizational tensions can fundamentally reshape the organizational values, identities, and power relations during major changes. In his seminal field study of a railway company, Dent documented how the introduction of a new accounting logic

gradually replaced the firm's traditional engineering-oriented culture, creating what he described as "a new organizational reality" Dent (1991). Formal performance measures and budgets were not merely neutral tools; they became carriers of a new set of beliefs about what matters in the organization. Dent's framework thus emphasizes the coupling of technocratic controls with local meaning systems – when a control system is embraced and internalized by organizational members, it can alter "the legitimacy of accepted criteria for action" Dent (1991, p. 4), thereby redefining which behaviours and outcomes are valued. In contrast, if such systems remain decoupled or purely ceremonial, they risk being viewed as "necessary but irrelevant" Dent (1991, p. 3) values that fail to influence day-to-day practice. Dent's (1991) cultural lens highlights that management controls have a dual character: they mediate power and identity as much as they measure performance.

The notion of accounting as identity regulation has long been elaborated by organizational theorists. Alvesson and Willmott (2002) define identity regulation as the deliberate shaping of employees' self-conceptions in line with organizational objectives. They argue that modern organizations increasingly rely on this subtle form of control: instead of monitoring behaviour directly, they influence how employees think about themselves and their roles. Accounting systems can contribute to identity regulation by signalling what is important and what defines success. For instance, when physicians in a hospital are required to engage with budgets and cost reports, over time they may start seeing themselves not just as care providers but also as "financially responsible managers" of resources. This phenomenon is often described as hybrid professionalism – a blending of professional identity with managerial (or accounting) identity. Research in top accounting journals has documented such hybridity. An example is the introduction of accounting into healthcare management in Finland, where clinicians began to adopt accounting logics in their decision-making; Kurunmäki (2004) showed that doctors became "hybrid" doctor-accountants, willingly using cost accounting to improve their operations. More recently, Golyagina and Valuckas (2020) examine how management accountants perform boundary-work to negotiate their professional identity in the face of globalization and expanded roles. They found that professional accounting bodies and practitioners engage in redefining the boundaries of the management accounting role,

alternating between defending their turf and expanding into new domains to maintain relevance. This suggests that as organizations demand more integration between technical and financial expertise (as is common post-acquisition), individuals undertake identity work to reconcile potential role conflicts. In an acquisition, for example, the acquiree's controllers might need to redefine themselves from being loyal to the local business to being part of a larger corporate finance team – a shift in identity that involves boundary spanning between old and new expectations.

Another related concept is socio-ideological control, introduced by Alvesson and Kärreman (2004) to describe control exercised through values, beliefs, and ideologies. This form of control operates by cultivating certain norms and identities rather than by explicit rules or metrics. For instance, a corporation might promote a strong "One Company" culture post-acquisition, encouraging employees to internalize the idea that "we are all part of the same integrated firm" regardless of prior affiliations. Such cultural messaging, often reinforced by accounting narratives (e.g. celebrating company-wide financial success), can align employees' identities with the new organizational context. Socio-ideological control is thus deeply intertwined with identity regulation – it works by shaping the mindset of employees so that they behave in the desired way voluntarily (because it fits who they believe they are). Importantly, socio-ideological control does not exclude technocratic control (formal systems); the two interact. Alvesson and Kärreman (2004) found that even in a highly people-oriented consulting firm, formal management systems (targets, evaluation processes) reinforced an ideological message of excellence and competitiveness, and vice versa. In the context of management accounting, recent studies also highlight how technical controls have symbolic and ideological impacts. For example, productivity metrics in professional work can create an "ideal self" of the productive, accountable employee, which workers may accept or resist Espeland et al. (2007); see also Morales and Lambert (2013) on accountants' identity under new public management).

2.3 Theoretical Framework

Bridging Busco et al.'s (2008) post-acquisition framework of managing tension through PMS with Dent's (1991) cultural perspective yields a theoretical framework for this study. Busco et al. (2008) identify three key tensions that must be managed when integrating an acquired unit. These tensions are inherently paradoxical – each side offers benefits but also poses risks if overemphasized. Prior literature suggests that a combination of formal performance management systems and informal cultural tactics can help navigate these tensions. Busco et al. (2008), for instance, emphasize the role of performance management systems (PMS) in achieving alignment with corporate objectives (supporting vertical control and convergence) while simultaneously enabling responsiveness to local conditions (supporting lateral relations and differentiation). Similarly, recent work by Carlsson-Wall et al. (2019) demonstrates that using technocratic controls (e.g. financial targets, standardized KPIs) in tandem with socio-ideological controls (e.g. shared values, vision communication) can effectively manage these three tensions in a multinational setting by securing high employee buy-in to the new systems.

Dent's (1991) cultural perspective adds an important, deeper dimension to this framework by explaining how such buy-in and cultural change can occur (or fail to occur) within the acquired unit. Busco et al.'s (2008) domain theory defines what needs to be balanced in structural terms; Dent's (1991) method theory highlights the meaning-making process that underlies those balances. In other words, managing integration whether it be vertical vs. lateral or centralization vs. decentralization, is not only a structural or design challenge – it is also a cultural one, involving shifts in how employees perceive authority, autonomy, and their own professional identity. Dent (1991) showed that a formal control system (an accounting plan, in his case) can carry ideological significance: it confers legitimacy on certain actions, empowers certain actors, and validates new norms about what is important. Applying that insight, we can theorize that when an acquirer introduces, say, a group-wide Balanced Scorecard or strict financial targets, these controls will do more than enforce compliance. If successfully internalized, they will start to shape the clinic's local culture – redefining "good

performance" in terms of corporate metrics and gradually encouraging veterinarians and staff to recalibrate their priorities. For example, measures of client satisfaction or profit per case might begin to subtly redefine professional notions of excellence in care, thus aligning the clinic's ethos with the acquirer's strategic goals. Over time, what was initially a vertical control mechanism can also become a lateral bonding mechanism, as the acquired clinic's members share in the new language and goals introduced by the parent company (thereby feeling part of a larger "one company" culture). Conversely, Dent's (1991) lens also alerts us to the possibility of resistance or superficial adoption: if the new controls starkly contradict the clinic's prior values, staff may comply only symbolically, described by Oliver (1991).

By integrating the above perspectives, this thesis's theoretical framework acknowledges that post-acquisition integration is both a structural and cultural process. The formal tensions identified by Busco et al. (2008) will be examined in the veterinary clinic context. At the same time, Dent's (1991) cultural perspective guides our interpretation of those instances – helping to determine whether the introduction of corporate controls is gradually realigning the clinic's cultural norms or whether deeper professional values are holding sway. This integrated approach aligns with calls in the literature to bridge technical control systems and cultural analysis. It also mirrors findings in recent case studies that a hybrid control model can emerge post-acquisition: one that mixes formal mechanisms with informal adaptations to achieve an acceptable balance described by Carlsson-Wall et al. (2019) as well as Alvesson and Kärreman (2004). In summary, the framework allows this study to analyze not just what controls or tensions exist, but why they take the shape they do and how they are navigated by organizational actors on the ground.

2.3.1 Research Gap

Prior studies of post-acquisition control have tended to focus on either large-scale integrations or purely structural aspects. Busco et al. (2008) and Carlsson-Wall et al. (2019), for example, examine integration tensions in multinational corporations and industrial settings, offering valuable insights into how formal systems can be used to

balance global vs. local demands. However, there is little research on how these tensions affect a small-scale professional service company culture post-acquisition. Veterinary clinics share characteristics with other professional organizations – with cultures centralized around specialized expertise, strong professional ethos, and client-centered missions – yet studies in accounting Dent (1991) and consulting Alvesson and Kärreman (2004) suggest that such contexts may respond to control systems very differently from typical industrial units. Empson's (2004) investigation of an accounting firm merger showed the integration hinged on managing identity and cultural change, but veterinary practices (with their caregiving values and norms of professional autonomy) have not been similarly explored. Thus, we lack understanding of how hard controls and soft values collide and co-evolve when a deeply mission-driven unit (a clinic of medical professionals) is absorbed into a profit-driven corporate group.

3. Methodology

3.1 Research Design

This study adopts a qualitative case study approach to explore the research question in depth. A single-case study is appropriate as the thesis examines a complex, context-dependent phenomenon. The case of the IVC-acquired equine clinic provides a rich setting to observe the tensions from the implementation of PMS and the cultural effects.

The research design is exploratory and interpretive leveraging multiple sources of qualitative data, with a primary emphasis on employee interviews, to construct an understanding of how they perceive and respond to changes in the post-acquisition phase. An interpretive stance, exemplified by Ahrens and Chapman (2006), is taken in analysing the data, meaning this study aims to understand events and controls through the meanings that participants assign to them. Given that the primary line of questioning lies in tensions and culture (which are inherently subjective), this approach is fitting. The data collection method has also been positioned to contribute to theory. Following Eisenhardt's (1989) guidance on building theory from case research, this study did not test a predetermined hypothesis but instead used theoretical concepts (like those from Busco et al. (2008),

Malmi and Brown (2008), etc.) as lenses to sensitize analysis and help highlighting relevant and re-occurring patterns.

In terms of temporal focus, the study was conducted approximately 2–3 years after the clinic's acquisition by IVC. This timing allowed us to capture the situation after initial integration steps had been implemented but while adjustments were still ongoing. It represents a phase where both acute reactions and some longer-term adaptations can be observed.

3.2 Data Collection

Primary data for this study was collected through semi-structured interviews with individuals at the case clinic. The interview method was chosen for its flexibility and depth – it allows respondents to describe experiences in their own words and for the interviewer to probe emergent topics, as described by Kvale and Brinkmann (2009). The interviews followed a guide aligned with a specific interest in technocratic controls, socio-ideological controls, and tensions (see Appendix), whilst remaining open to new insights that interviewees brought up suggested by Rowley (2012). All interviews were conducted in person at the equine clinic, providing opportunities to observe the setting informally and build rapport.

Sample and Participants: 11 interviews in total were conducted, encompassing a cross-section of roles in the clinic. Participants were selected to ensure representation from different hierarchical levels and functional perspectives, ensuring a holistic view of the clinic's operations and culture. Four broad role categories were defined and interviewees selected in order to interview multiple employees in each. These categories are as follows:

1. Partner Veterinarians: Senior vets with a management or ownership background (pre-acquisition). These individuals provide insight into leadership decisions, changes in governance, and strategic perspectives both before and after IVC's takeover.
2. Associate Veterinarians: Vets without managerial duties. They represent the professional staff whose primary focus is clinical work, offering perspectives on how medical practice and daily routines were affected by new controls.

3. Veterinary Nurses/Technicians: Clinical support staff who handle nursing care, assist in procedures, etc. They experience the frontline impact of process changes and can share insight on teamwork and workload.
4. Administrative Staff: This includes receptionists, billing/accounts personnel, and practice managers. They deal heavily with the administrative systems (scheduling, finances, procurement) and often interface with IVC's central requirements, making their viewpoint crucial on technocratic control impact.

The final interview roster (Appendix) had a mix of these roles, for example: two partner-vets, several vets, nurses, and administrative staff. This diversity helped in triangulating accounts – for instance, if both a vet and an admin described issues with a new reporting system, the study gained confidence, validating that it was a significant issue and not just one person's concern.

Interview Procedure: Before formal interviews, a pilot interview with one staff member was held (who was not part of the main sample) to test the questions for clarity and relevance, as by Chenail (2011). Based on this pilot, the wording of certain questions was refined and ensured the full coverage of all key topics (controls and tensions) without leading the interviewee.

During the actual interviews, steps were taken to make the conditions conducive to open dialogue. All interviews took place in a private room at the clinic during working hours (but scheduled to avoid emergencies). Privacy helped interviewees speak freely about potentially sensitive topics (such as criticizing new systems or management). Consent was obtained to audio-record each interview, emphasizing confidentiality. To protect anonymity, no questions that would elicit personal identifiers or sensitive personal data were asked; when discussing internal events or policy implementation, the focus was on roles and processes rather than individual grievances.

Each interview lasted between 20 to 45 minutes (see Appendix 1 for details). The style was conversational starting with general, contextual questions (e.g. "How long have you been with the clinic and what's your role?") and then moving into thematic sections.

The semi-structured format allowed us to follow up on some interesting points. For instance, if an interviewee mentioned a specific incident (like a corporate meeting where redundancies were announced), they would be encouraged to narrate that event and their feelings about it. These stories became valuable case evidence of how controls were enacted, and reacted to in real-life scenarios.

After each interview, the audio recording was transcribed verbatim. Brief field notes were kept during and after interviews to capture non-verbal impressions or contextual details (e.g. an interviewee's tone when discussing a topic, or an interruption that occurred, etc.). These helped in interpretation later in the analysis.

It's worth noting that by the later interviews, certain themes had started to recur (e.g. multiple people complaining about a particular software system), indicating the study was reaching a point of thematic saturation where additional interviews were yielding diminishing new information Guest et al. (2006). Given the intensive nature of each interview and the consistency of key points, it was judged the sample of 11 to be sufficient for the study's purposes.

3.3 Data Analysis

The interview data was analysed using thematic analysis, as described by Braun and Clarke (2006), a method well-suited for identifying patterns in qualitative data. The study followed a structured but iterative process:

Familiarization: All transcripts were read in full multiple times. In this phase, full immersion in the raw data, noting initial impressions was the primary goal. It was observed early on that words like "corporate," "number," "standardized," and "pressure" were frequently mentioned unprompted, whereas words like "family," "personal," "flexible" often came up when talking about the past – hinting at a cultural shift theme.

Initial Coding: the next phase was to code the transcripts line-by-line, assigning short labels to segments of text that represented a specific idea or issue. Using a mixture of deductive codes (informed by a theoretical lens) and inductive codes (grounded in what participants said). Deductive codes included coding rules such as

“vertical_control_issue,” “lateral_coord_absent,” “standardization_push,” “local_resistance,” corresponding to selected tension categories. Inductive codes captured emergent concepts such as “feeling like a number,” “extra paperwork,” “client complaints about prices,” “loss of trust,” “improved equipment,” etc.

Searching for Themes: Next, the codes were analysed for them to be grouped into broader themes. Particular interest and focus was put into themes reflecting the tensions from the study’s framework and culture. The findings were that many codes clustered under the anticipated tension areas, for example: “feel isolated from other clinics” and “no knowledge sharing” grouped into a theme labeled “Limited Lateral Relations” (the flip side of vertical vs. lateral). Codes such as “one-size-fits-all protocols,” “pricing issues,” and “workarounds” merged under the umbrella “Convergence vs. Differentiation in Practice”.

A strong theme around “Culture Shift and Identity” was also identiffied, as many codes were attributed to changes in how staff felt valued or the ethos of the clinic.

Defining Themes and Narrative Building: After finalizing themes, each theme was described qualitatively in detail, relating it back to the research question and literature. Visual maps were used as a tool to understand the relationships between themes. For example, “Culture Shift and Identity” was a backdrop that influenced how people perceived “Performance Metrics” (a technocratic element). This stage is where the findings section built its initial structure: deciding an order to present themes that would logically tell the story of what happened at the clinic.

Contextualizing with Theory: In the final interpretation, the themes related back to the theoretical concepts from the literature review. the study examined whether the data supported, extended, or challenged prior findings. For instance, Busco et al. (2008) explored the need for lateral relations – the data strongly reinforced that by showing problems when lateral relations were absent. On the other hand, the findings of this case study provided a twist on Alvesson and Kärreman (2004) – they found technocratic and socio-ideological controls can reinforce each other in consultancy; in the studied clinic, initially they clashed, but later partial reinforcement appeared.

By following these steps, the analysis remained systematic while also allowing the nuances of the clinic's qualitative evidence to emerge. Care was taken to maintain chains of evidence: for each assertion in the findings, specific interview quotes or instances are evidenced as support. The qualitative approach and thematic analysis enabled the study to delve into the how and why of the integration outcomes, capturing the voices of those experiencing it. In the next section, the findings organized by major themes, intertwined with analysis, to address the research question are presented.

4. Findings and analysis

4.1 Vertical vs. Lateral Relations

Limited Lateral Collaboration Across Clinics

Despite now being part of a large veterinary group, staff at the case clinic reported very little horizontal interaction or collaboration with other clinics after the acquisition. Day-to-day, each clinic "operates in its own silo," as one veterinarian put it (Interview 4). The interviewee continued, "I haven't had much relationship with other clinics… no real synergy." This was the dominant sentiment: joining Independent Vetcare (IVC) did not translate into feeling part of a wider community or team of clinics. The acquisition brought a change in ownership and reporting lines, but not a sense of collegial integration with peer clinics even though there were examples of lateral relations they were limited.

However, it was clear that these rare collaborations happened despite the formal organizational structure, not because of it. Staff emphasized there was no strong framework or encouragement from IVC to foster lateral exchange. "I feel part of the same team [with other equine vets], but the company doesn't facilitate that. Which is a shame," observed a senior clinician (Interview 9). In fact, elements of IVC's post-acquisition organizational design may have inadvertently hampered lateral ties. Equine clinics were regionally grouped together with predominantly small-animal clinics, meaning that in any given locality there might not be another equine hospital to easily

interact with. One vet noted, “They lumped us in a region with pet clinics, which provides no useful collaboration for an equine hospital… it feels as if I’m still on my own” (Interview 4). In other words, the grouping strategy failed to account for specialty, leaving the equine clinic without like-for-like peers nearby.

Notably, some staff had expected more cross-clinic interaction as a benefit of being acquired by a large veterinary group – and were disappointed that it didn’t materialize. There were hopes for knowledge-sharing forums, joint training sessions, or even social events connecting clinics under the IVC umbrella. The reality was far more limited. The only time many employees met colleagues from other clinics was at an occasional company-organized professional development day – essentially an internal conference. Those who did attend found it valuable, both for learning and for simply realizing everyone experienced the same lateral limitations. It gave a glimpse and excitement of belonging to a larger professional community. For example, interns who had trained at the case clinic and then moved to other IVC clinics reconnected at the event and swapped experiences about different practices, which they found enlightening (Interview 8). This suggests that when lateral contact was facilitated even in a small dose, it boosted morale and a sense of community. It made staff aware that they were part of something bigger, counteracting the isolation – at least temporarily.

From a theoretical standpoint, the lack of lateral integration meant IVC was not capitalizing on horizontal coordination mechanisms that can promote learning and consistency across units. Prior research highlights that lateral or network ties (e.g. communities of practice, cross-unit teams) are crucial in multi-unit organizations for spreading best practices and building a shared culture, described by Chenhall et al. (2013). In the clinic’s experience, each unit was largely left to “reinvent the wheel” or solve problems on its own. For instance, if one clinic developed an effective debt-collection method or a great client communication tip, there was no system or platform for others to hear about it. As a result, good ideas remained local, likely leading to avoidable inefficiencies and inconsistent client experiences across the group. Several interviewees described the situation as a missed opportunity – being part of

IVC could have brought fresh knowledge, referrals, or a support network, but instead "it feels as if I'm still on my own" (Interview 4).

Strained Vertical Relations with Headquarters

If lateral relations were defined by their absence, the vertical relations– i.e. the interactions between the clinic and the IVC headquarters/management hierarchy – were characterized by frequent contact but high friction. Nearly every interview touched on problems in communicating with, and aligning to, IVC's management structure and style. The relationship between the frontline clinic and the distant corporate center emerged as a source of tension and frustration.

One recurring complaint was the multi-layered management structure and resulting slowness or opacity in decision-making. The clinic was now part of a much larger hierarchy, and staff felt that even straightforward issues became protracted. "My line manager has no ability to make decisions on her own… everything has to go to a regional director and then up [the chain]," explained the clinic's director (Interview 10). This extended chain of command meant that local requests or issues often bogged down in approvals. A concrete example was given regarding an unexpected staffing crisis: the clinic faced the sudden long-term absence of a veterinarian due to a health emergency. Local management urgently requested that HQ fund a temporary replacement or at least adjust the clinic's performance targets to account for the staffing shortfall. Headquarters did respond initially – HQ eventually approved paying the vet during the leave of absence (showing some willingness to support the clinic) – but this decision "went all the way up to the top" for approval and then seemingly got lost when the corporate finance department later reviewed the clinic's numbers. In the clinic's subsequent profit reports, they were effectively penalized for the extra personnel cost that they thought HQ had agreed to cover (Interview 10).

Communication from HQ was often described by clinic employees as "direct and tone-deaf." Staff noted that most messages from higher-ups revolved around financial targets and directives, with little acknowledgment of on-the-ground realities. For example, an administrative staff member gave a telling example: if reported monthly figures didn't

match HQ's projections or targets, they would be instructed that "your figures must be wrong, re-run everything," only to find (after re-checking) that the numbers were indeed correct and the real issue was HQ not understanding a nuance of the clinic's situation (Interview 7). This indicated a lack of trust or listening from above—corporate's first assumption was that the clinic made an error, rather than questioning their own assumptions. Such exchanges resulted in redundant work and considerable frustration on the clinic's side.

A particularly stark incident, remembered bitterly by several staff members, was when HQ convened a meeting and effectively threatened mass redundancies unless certain costs were cut within about 10 days. "They instilled fear in everybody about job losses," a vet recounted (Interview 4), explaining that corporate managers dropped this bombshell seemingly unaware of how an equine 24/7 hospital could possibly slash costs so rapidly without harming operations or patient care. Later, HQ backtracked when they realized the clinic's unique staffing needs (recognizing that a round-the-clock emergency hospital could not be treated the same as a daytime pet clinic for cost cuts), but the damage was done – the episode severely damaged trust. Employees saw it as proof that HQ did not understand the business and was willing to make drastic, ill-informed decisions regardless of local consequences.

Another area where this disconnect surfaced was pricing decisions. HQ unilaterally imposed price increases for services as part of their revenue growth strategy. Local staff warned that these hikes were excessive for their rural equine client base and would likely drive clients away. Initially, their input fell on deaf ears. Only after seeing an actual drop in client visits and revenues did HQ reconsider the pricing strategy – a response that felt reactive rather than consultative (Interview 1). In other words, HQ learned the hard way what local staff already knew – an example of how not engaging local expertise upfront led to poor decisions. It underscored the cost of failing to incorporate bottom-up insights: the organization had to suffer tangible setbacks (lost revenue and goodwill) before adjustments were made.

The consequences of these strained vertical relations were tangible. Morale at the clinic suffered, and in the year following the acquisition, several senior staff members chose to leave the organization – a mini "brain drain" that took away valuable expertise and further strained the clinic's operations. Those who remained admitted to developing an "us vs. them" mentality: the clinic staff bonded together in their shared frustration with HQ. While this solidarity among local colleagues was a coping mechanism, it is culturally corrosive in the long run, because it reinforces silo thinking and a reflexive resistance to any new corporate initiative (viewed with suspicion as coming from "them").

In summary, the Vertical vs. Lateral tension in this case was resolved not managed in a one-sided way: IVC leaned heavily on vertical, hierarchical control and largely neglected lateral, peer-level integration mechanisms. The outcome was an imbalanced integration characterized by vertical strain and lateral void. From Busco et al.'s (2008) structural viewpoint, the company over-emphasized vertical relations (imposing performance metrics, directives, and centralized decisions) without the counterweight of lateral relations (sharing knowledge, building community across clinics) that might have fostered unity and learning.

HQ communication should strive to be supportive and empathetic – for example, balancing performance discussions with acknowledgement of local achievements and challenges, and avoiding sudden, unilateral edicts that erode trust. Drawing on Kraus et al. (2016) where an Non-Governmental Organisation, used "ideological talk" which created more control and where ideological controls explained less resistance of implementing MCS. Consistent with Busco et al. (2008) and others, managing global–local tensions require consciously balancing vertical and lateral dimensions in tandem, described by Carlsson-Wall et al. (2019). IVC's integration shows the risks of skewing too far toward one side: robust vertical enforcement with weak lateral and upward flows bred resentment and lost opportunities for synergy. Bringing those dimensions into better balance would likely have led to a smoother integration both operationally and culturally.

4.2 Convergence vs. Differentiation

Push for Convergence by IVC

In line with many corporate acquisitions, IVC sought to standardize processes and policies across its clinics for consistency, control, and scalability. Management introduced several standard practices at the equine clinic, including: a centralized pricing structure for services, preferred supplier contracts and centralized procurement, group-wide HR policies (e.g. standardized terms for leave, performance appraisal), and plans to unify clinical IT systems across all clinics. From HQ's perspective, these convergent practices were intended to enable easier monitoring and to exploit efficiencies of scale (for instance, negotiating bulk discounts with suppliers, enforcing consistent branding and customer experience, and gathering comparable financial data from all clinics). Such standardization is a common integration strategy to create a "single way of working" in the merged organization, as set out by Granlund (2003).

Staff at the clinic indeed noticed these efforts. One of the most visible changes was being expected to adopt IVC's centralized price lists for treatments and medications. Prices for procedures were now set according to corporate's analysis and targets, rather than based on the clinic's prior local pricing or the specific economic context of the region. Another change was in recruitment: the clinic was instructed to route all hiring through IVC's central HR recruitment team, instead of local managers advertising and hiring staff directly. Additionally, IVC rolled out standard operating guidelines accessible via an intranet – documents providing recommended clinical protocols for common medical conditions (these were primarily developed for small-animal clinics, but they were distributed to equine clinics as well) – and standardized health and safety procedures. In short, a suite of formal policies and tools was introduced to make the clinic's operations align with those of the wider group.

Some aspects of this convergence were benign or even helpful. For example, the clinical guidelines provided a useful reference for less-experienced veterinarians. "IVC produced some [clinical] guidelines… to help young vets handle cases in a consistent way," noted a senior vet (Interview 4). Junior staff appreciated having these documents as a baseline –

it gave them confidence that they were following recognized best practices and not "winging it" alone. In this sense, the convergence in clinical protocols functioned as a form of knowledge sharing from the center to the periphery. It also had a subtle socio-ideological angle: by reading and using the same guidelines as their peers in other locations, new employees could feel part of a larger, modern organization with established methods, which might accelerate their identification with the company. This resonates with observations by Alvesson and Kärreman (2004) that even ostensibly technocratic controls (like manuals or standard procedures) can carry cultural weight by signaling "how we do things around here." In our case, not all standardization was met with resistance; when a standardized tool met a real operational need (such as training new graduates) and was framed as support rather than bureaucratic control, it tended to be welcomed by staff.

Despite the rational motivations and some benefits of these changes, many staff perceived the standardization drive as a double-edged sword. The upsides were acknowledged: greater consistency, potential efficiency gains (for instance, the centralized purchasing did yield volume discounts on supplies, and having a formal HR policy provided clarity on procedures for things like grievances or leave entitlements which had been informal before). However, the downsides were keenly felt as well: a loss of flexibility and the imposition of processes that didn't always fit the clinic's local context or preferences. A senior nurse observed that as the clinic became more entangled in corporate procedures, "staff aren't utilized to their full potential." She elaborated with examples: employees who used to wear multiple hats and apply their broad skill sets were now constrained by narrowly defined roles or slowed down by new bureaucratic tasks that never existed before. This suggests that some of the standardized protocols, while bringing order, also inadvertently stifled local initiative and adaptability. It reflects the classic tension between "enabling" versus "coercive" formalization Adler et al., (1996) – in this case, much of the convergence was experienced as coercive or restrictive by the staff rather than empowering.

One of the most contentious areas of convergence was pricing, as hinted above. Corporate's habit of instituting regular price increases ("they always want to increase

prices to hit growth targets," as one partner vet lamented) led to shock for some of the clinic's long-standing clients. "That scared off a lot of my clients," the vet continued, explaining that local horse owners in their rural area were price-sensitive and had alternatives (such as independent solo practitioners or simply opting for less frequent preventive care). In one region, competitors undercut IVC's new pricing, resulting in a noticeable drop in business – the opposite of the intended revenue growth. Here, the push for convergence (a uniform pricing strategy for all clinics) backfired due to local market differentiation. A strategy that might have been tolerable in an urban small-animal context failed in a rural equine community. This example underscores a key integration lesson: one size does not fit all, and imposing uniform practices without regard to context can undermine performance. It resonated strongly with staff, who felt vindicated that their local knowledge (which had been initially ignored) proved important. This also highlights the shifts in the identity of the clinic which previously had put clients and animals first while now focusing on the profit which shows similarities to Dent (1991) with the difference of a clinic wide resistance of the new ideology of the company.

Persistence of Local Adaptation and Autonomy.

Despite the top-down push for uniformity, the clinic managed to maintain some degree of localized practices and autonomy – illustrating the pull of differentiation even under a convergence regime. This occurred partly by necessity (certain local conditions simply required local solutions), partly through deliberate flexibility on IVC's part in some domains, and partly via quiet resistance or workarounds by the clinic staff. In combination, these factors meant that the clinic did not become a carbon copy of other clinics; rather, it operated with a hybrid of new and old practices.

First and foremost, in the realm of clinical work, virtually all interviewees stressed that they retained substantial professional freedom in treating patients. Corporate might issue recommended protocols and guidelines, but these were not strict mandates. "There isn't that much from a clinical point of view [being imposed]; I have a lot of clinical freedom," said a senior vet (Interview 1). Veterinarians continued to exercise their professional judgment for each case. They diverged from corporate suggestions whenever they felt the

case warranted it or a client's situation demanded a different approach. This autonomy is deeply ingrained in veterinary (and more broadly, medical) culture – ultimately, the vet on site must decide what's best for the animal in front of them, balancing medical and ethical considerations. Recognizing this, corporate largely respected the clinical domain as the vets' territory. In fact, pushing too hard on standardizing medical decisions would likely have provoked outright rebellion or a decline in care quality – an outcome IVC wisely avoided. In Malmi and Brown (2008) management control terms, IVC set broad boundary controls (ethical standards, basic treatment protocols) but left core operational decisions decentralized to expert professionals. This maintained the staff's sense of professional integrity and safeguarded patient care standards. As one specialist noted, "From a clinical perspective, I can still do what I think is right for the horse… They haven't tried to impose 'you must use Treatment X for Condition Y' – that would never work" (Interview 2). This preservation of clinical freedom acted as a sort of pressure valve: it ensured that, even as other aspects of work were being standardized, the heart of the professionals' work – caring for animals – remained under their control. That made the other impositions somewhat more tolerable; staff could reassure themselves that "at least when it comes to treating our patients, we still call the shots." In cultural terms, this helped sustain the vets' professional identity as autonomous caregivers, even while their organization underwent changes. Dent's (1991) insights remind us that such professional identity is powerful – in this case, the new control systems did not attempt to usurp the clinicians' core sense of purpose, which likely prevented a more severe cultural clash.

Second, the clinic engaged in local adaptation in administrative and accounting processes, sometimes beyond what corporate might have realized or officially sanctioned. A prime example was the creation of vernacular (informal) accounting systems by the clinic's staff to cope with new corporate systems. The clinic's accounts manager developed her own Excel spreadsheets and tracking methods to manage the clinic's finances day-to-day, because the central accounting system made it difficult to get a clear, real-time picture at the clinic level. "I've got my own process really… my own spreadsheets I set up so I can watch what's coming in and going out," explained the

interviewee (Interview 7). This "shadow" system let the employee quickly see which clients owed money, which services were most profitable, etc., tasks that the corporate software complicated with its multi-layered structure. Essentially, the local system re-created the visibility and agility that was lost when accounting became centralized. This is a textbook case of differentiation under the radar – tailoring the control system to local needs by deviating from official processes. Interestingly, such employee-initiated adaptations can improve the overall functioning of control systems. Goretzki et al. (2017) found that when local actors build supplementary tools (like spreadsheets) to bridge gaps in corporate systems, they often enable the formal system to work better by providing timely information and flexibility. In this case, without localized spreadsheets the clinic's financial management would have been subject to cumbersome corporate reports lacking in oversight; with them, the clinic maintained internal clarity and could make quick decisions (for instance, chasing an overdue client payment) while still ultimately feeding data into the corporate system. This kind of pragmatic resistance did not openly defy IVC's controls – the manager still submitted all required reports – but it optimized local operations. It demonstrated a subtle form of resistance that aids performance, illustrating that differentiation can be constructive.

Several instances demonstrate a form of strategic resistance by the clinic – not outright rebellion, but pragmatic adaptation to balance corporate demands with local reality. Oliver's (1991) framework of strategic responses to institutional pressures is useful here: rather than either fully acquiescing or openly defying, the clinic often engaged in compromise and internal buffering (e.g. decoupling actual practices from formal policies). Employees complied with the new systems to the extent necessary (they filled out the reports, used the purchasing system, followed the broad guidelines), but simultaneously preserved their own ways of doing things to keep operations smooth and congruent with their standards. This resulted in what one might call a dual operating system at the clinic – the official corporate-mandated system and the informal local system – coexisting. It's reminiscent of the common phenomenon where staff say, "We do what we have to do on paper, but we really operate like this." In the context of post-

acquisition integration, this duality is not unusual when imposed controls are seen as misaligned or impractical.

From a performance standpoint, these local adaptations likely cushioned the clinic from some negative effects of rigid convergence. For example, without the administrator's custom spreadsheets, the new centralized accounting might have caused the clinic to lose track of day-to-day finances, potentially harming cash flow or leading to missed billing – but her adaptation prevented that. Similarly, by informally maintaining a personal touch with clients, staff possibly retained client loyalty that could have been lost if they had strictly followed a more impersonal corporate script; this directly impacts customer retention and revenue. In this sense, the staff's differentiated practices were bolstering the clinic's performance, even as they contravened full standardization. This aligns with the concept of enabling control systems Adler et al.(1996) – when employees tweak and customize control processes to make them more useful and context-appropriate, they are effectively turning coercive rules into more enabling ones for themselves. Here, the employees' bottom-up adaptations made the imposed systems work better in their setting.

The dynamics above illustrate the nuanced balance between standardization and localization in integration. For IVC, many of its one-size-fits-all policies encountered the reality that local context matters. The clinic's experience suggests that effective post-acquisition integration may require an iterative, flexible approach: initial standardized frameworks should be adjusted as needed to accommodate on-the-ground conditions. Simply imposing uniformity can undermine the very goals of integration if local units cannot operate effectively or if morale and client relations suffer. At the same time, allowing some differentiation does not necessarily mean losing control; as we saw, local innovations and workarounds often helped maintain performance and were not acts of rebellion so much as efforts to align corporate systems with local realities.

From a theoretical perspective, the study's findings echo Busco et al.'s (2008) point that integration involves managing convergence vs. differentiation and show that in practice organizations often arrive at a hybrid position. In this case, a hybrid control package emerged: formal convergence in administrative domains, informal

differentiation in operational and cultural domains. This aligns with the notion of a management control system package Malmi and Brown (2008) where different controls (technocratic and socio-ideological) interact – here the formal controls were tempered by informal norms and practices.

4.3 Centralization vs. Decentralization

A Dual Structure of Decision Authority.

After the acquisition, formal decision-making became highly centralized in certain areas. Strategic decisions, significant capital expenditures, budgeting and financial planning, HR policy enforcement, and other "administrative" matters were now largely made by or had to be approved by headquarters. The clinic could no longer independently decide on things like hiring an extra nurse, purchasing an expensive piece of equipment, or adjusting its operating hours without consultation and approval from the regional or central management. These changes were in line with IVC's goal of having greater oversight and more uniform governance across its clinics. On the other hand, day-to-day operational and clinical decisions remained mostly decentralized at the clinic level. As discussed in the previous section, veterinarians retained autonomy in medical decisions – HQ did not attempt to micromanage clinical judgment.

This arrangement can be seen as IVC implicitly acknowledging the need for local expertise in operations while still asserting control over outcomes via centralized oversight. The pattern aligns with what Jacobs (2005) describes in professional organizations: informal control through professional norms and discretion coexists with formal control through budgets and policies. The key – and challenge – is achieving a balance that doesn't demotivate either side. In our case, the balance was imperfect but somewhat functional: staff accepted centralization in many areas because they still had freedom in the areas that truly mattered to them (i.e. clinical work and immediate client service). One could say the clinicians tolerated corporate control over "business" decisions if their professional domain was left intact.

One telling incident reflecting this was when HQ demanded cost cuts (via threat of redundancies). While HQ did not explicitly encourage compromising patient care, the clinic staff immediately saw that such cuts would inevitably harm their ability to deliver 24/7 emergency coverage – a clear collision of corporate financial control with clinical mission. Staff felt that business decisions were being made in a vacuum and could seriously compromise the practice if implemented. Another example was the drawn-out approval for hiring a replacement vet: the clinic's management wanted to quickly fill a crucial role (because until then, remaining vets had to cover extra shifts), but the centralized HR process delayed this, affecting work-life balance and in some cases patient wait times. Thus, even with professional autonomy formally intact, the effectiveness of that autonomy was at times undermined by centralized constraints.

Overall, the case clinic ended up with a hybrid decision structure: centralized administration, decentralized professional work. This compromise had clear advantages in preserving professional autonomy, and indeed it may have prevented the integration from failing outright – as noted, many vets might have left immediately if their clinical autonomy was taken. However, the integration tensions were not eliminated by this compromise; they were transformed. Instead of open rebellion on clinical decisions, the tensions surfaced in more subtle forms, like cynicism about HQ's financial directives, quiet workarounds as described, and internalized stress among staff trying to meet corporate demands without sacrificing care.

The pattern observed suggests that acquirers of professional organizations should carefully choose what to centralize and what to leave decentralized, mindful of the professional identity and practical needs of the acquired unit. IVC likely got one thing right: not interfering in clinical decision-making. That preserved goodwill and ensured that the core service (animal care) was not degraded by bureaucratic interference. However, IVC perhaps underestimated how much even their indirect centralization moves (like uniform financial targets) could disrupt the clinic. A lesson for practice is that when centralizing certain decisions, the company should involve local professionals in the conversation to foresee impacts. For instance, setting pricing or budget policies with input from the clinicians could yield more realistic targets that achieve corporate

aims without hampering client service or staff morale. Centralization should be accompanied by consultation – a centralized decision need not be a dictatorial one if it's informed by those who will feel its effects.

From Busco et al.'s (2008) perspective, the centralization vs. decentralization tension is about finding the right configuration of decision rights in a global organization. This case provides a nuanced example: it wasn't all-or-nothing but a mix. It aligns with the idea that some decentralization must persist for local flexibility. However, the case also highlights that simply dividing domains (corporate handles X, local handles Y) isn't a foolproof solution and that the domains interact. Thus, mechanisms to manage that interface are critical. For example, if pricing is centralized, it could be suggested to give local managers limited discretionary power to offer discounts or adjust prices for special cases – thereby injecting a bit of decentralization into a centralized system to account for local conditions. Or conversely, if clinical operations are decentralized, ensure centralized planning takes their data and feedback into account so that corporate plans are realistic.

In conclusion to the analysis, the three tensions – vertical vs. lateral, convergence vs. differentiation, and centralization vs. decentralization – were all clear in this post-acquisition case. Each was only partially resolved, leading to ongoing frictions but also to a hybrid state of integration. The acquired clinic neither became fully homogenized into the parent corporation nor remained as independent as before; instead, it found a new equilibrium that combined elements of both. This came about through a process of negotiation (explicit and implicit) between the formal systems imposed by IVC and the informal responses of the clinic's staff. The result was a mixed outcome: initially, tensions were high, and performance and morale suffered in some respects, but over time, adaptations by both HQ and clinic allowed for some reconciliation – a tentative alignment of corporate controls with local practice.

4.4 Cultural Responses to Structural Tensions

Vertical vs. Lateral: What the findings add is a cultural dimension to this: the absence of lateral ties meant that the staff's social identity remained local. They never internalized

being part of "IVC at large," which made the vertical controls feel even more externally imposed. In other words, because employees did not develop peer relationships or a broader community feeling, they had no emotional stake in the larger organization's success – only in their clinic's. This arguably amplified the vertical tension: headquarters was seen as a distant authority, not as fellow colleagues with shared goals.

From Dent's (1991) perspective, this reflects the clinic staff clinging to their old organizational identity (the close-knit, independent clinic) and perceiving the new corporate authority as an external force misaligned with their values. The formal controls and directives coming from HQ took on an almost ideological character in the eyes of staff – representing a "profit-driven" ethos that conflicted with the clinic's prior ethos of personalized care. When employees start defining themselves in opposition to management ("we" the clinic vs. "they" the corporate), it is a strong sign that cultural integration has failed to accompany structural integration.

In Dent's (1991) cultural terms, this lack of lateral community meant that staff continued to identify primarily with their own clinic, not with the broader corporation. No "network culture" took root to bind the various clinics together. Informally, employees remained loyal to their local team (the people they saw every day) and did not develop loyalty to or familiarity with colleagues elsewhere but also to the corporation. This would later reinforce resistance to corporate initiatives, because there was no peer-level social pressure to conform to group norms – only top-down pressure from headquarters. This is further emphasized through the positive of comments of the few times collaboration had existed, highlighting the potential it could have to contribute to an improved culture.

From Dent's (1991) cultural viewpoint, this approach ignored the social and identity needs of the acquired employees – the staff never truly "bought into" being part of a larger group and instead developed defensive subcultures. The vertical control systems implemented by HQ – budgets, targets, reporting – became, in Dent's (1991) terms, infused with ideological significance, symbolizing to staff a new corporate "value

system" that prioritized financial outcomes over the personal, familial culture they cherished. Lacking informal social integration to buffer and humanize these changes, staff reacted by drawing a sharp us-versus-them boundary, which only heightened the tensions.

Dent's (1991) work suggests that when formal structures change, they need to be infused with meaning and legitimacy to be accepted. In our case, IVC's failure to integrate laterally left a meaning void – employees could not see the human face or purpose of the big corporate structure. Thus, vertical directives were often met with skepticism or resistance because they carried an ideology that felt alien (profit and efficiency) and came from people with whom the clinic staff had no personal connection. The "us vs. them" mentality that emerged is precisely what Dent's (1991) cultural lens would predict in such a scenario: lacking cultural integration, formal integration breeds division. Our findings, therefore, reinforce the idea that structural and cultural integration must go hand in hand. An organization chart was changed (structural), but the hearts and minds were not (cultural), leading to incomplete integration.

Interestingly, the few instances where lateral integration did occur (e.g. joint training days, inter-clinic help with equipment or procedures) had outsized positive effects on staff morale and openness to the new regime. This indicates that even modest efforts at building lateral camaraderie might have eased the vertical tensions, by giving employees a sense that they are part of a larger professional community rather than a faceless corporation. In theoretical terms, it suggests that informal networks (social capital) can reinforce formal control systems by creating goodwill and shared understanding Busco et al. (2008) noted that informal mechanisms can either reinforce or undermine formal systems; here we saw the absence of informal ties undermined them). Future integration efforts might explicitly incorporate lateral team building as a strategy to prevent the silo mentality we observed.

Convergence vs. Differentiation: What explains which controls were accepted and which were resisted? Here, Dent's (1991) perspective provides insight. Employees were more willing to accept changes that did not threaten their core professional identity or local

pride, and that could be aligned with their sense of "how we do things." For example, the standard clinical guidelines were embraced because they were framed as support for vets and aligned with their identity as competent caregivers wanting best practices. In contrast, the uniform pricing policy clashed with the staff's knowledge of their community and their value of client relationships, and so it was passively resisted and ultimately had to be reconsidered by HQ. In essence, when convergence initiatives resonated with local values or needs, they gained traction; when they collided with them, the clinic found ways to maintain differentiation. This selective implementation is a form of what Oliver (1991) calls selective compliance or compromise – the clinic neither wholly rejected nor wholly accepted corporate practices but negotiated each on its merits.

Dent's (1991) cultural lens further reveals that employees will actively interpret and respond to convergence efforts considering their existing values: when new systems threatened their professional ethos or local norms, they either repurposed them (using them as guidelines rather than strict rules) or created parallel solutions. Thus, the cultural acceptance of standardization is as important as the technical design – if staff view a new control as illegitimate or misaligned with "the way we should work," they will find ways to uphold their own approach. Integrators should therefore not only roll out systems but also work to align those systems with the identity and values of local employees, or conversely, work to reshape those identities gradually so that what is being standardized feels sensible rather than alien. In Dent's (1991) terms, formal control systems carry ideological significance – they signal what the organization values. If those signals clash with deeply held professional values, employees may comply in form but will resist in substance.

From a cultural perspective, the centralization of "business" matters introduced a new ideological element that staff had to grapple with. Pre-acquisition, the clinic's decision-making was mostly local and driven by a professional/service logic (e.g. "What do we need to do to best serve our clients and keep the practice healthy?"). Post-acquisition, many decisions were driven by a corporate logic of efficiency and growth targets. This shift meant that the staff's day-to-day choices were now influenced by an

external set of priorities. Dent (1991) showed how the introduction of formal accounting controls in an organization infused it with new ideological significance – in his case, a shift from an engineering ethos to a financial ethos. In our case, something similar occurred: the ideology of cost efficiency and financial performance became much more salient. Staff frequently heard about budgets, KPIs, and cost benchmarks – something largely absent before. This created a sort of internal conflict for many employees. They described feeling "torn" between doing what's right for patients or staff and hitting the numbers expected by HQ (this sentiment emerged in multiple interviews, even if not always in those exact words). Thus, although the formal decentralization of clinical decisions remained, the cultural perception was that the clinic was now expected to prioritize financial outcomes in a way it previously hadn't. Several employees remarked on this cultural shift (as we will discuss more fully in the next section on overall culture): a move "from a personal touch to a profit focus." That phrase encapsulates how the centralizing of financial control introduced a profit-oriented mindset that clashed with the prior ethos of the clinic.

One theoretical implication here is the importance of viewing resistance not merely as an obstacle, but as feedback in integration. The local adaptations we observed (spreadsheets, personal client service, etc.) were essentially the clinic's feedback that certain corporate controls were not fit for purpose. Rather than seeing them as insubordination, management could interpret them as information about where the corporate model needed refinement. By eventually allowing an "opt-out" in one program and tolerating some deviations, IVC implicitly learned and adapted as well. This dynamic aligns with adaptive organizational change theories and suggests that post-acquisition integration might benefit from a more experimental mindset – trying convergence but listening closely to local responses and being willing to iterate.

Centralization vs. Decentralization: From Dent's (1991) perspective, one can interpret the centralization of administrative control as the introduction of a new ideological regime in the organization – one focused on financial rationality. The local staff's uneasy reaction

to this (feeling a shift from "caring" to "numbers-driven") echoes what Dent (1991) described in his study: employees' sense when the underlying values of their organization are changing. In the vet clinic, the formal messages now stressed profit, cost, growth – whereas previously the implicit values were service, compassion, collegial loyalty. This cultural dissonance manifested in remarks about corporate being "clueless" or not caring, and in morale issues. Therefore, our findings emphasize that centralization is not only a structural move but a cultural one: it tends to carry with it the culture of the centralizers (often a more corporate, finance-oriented culture) and impose that on a local unit. If unmanaged, this can create what we saw: staff who comply outwardly but maintain an inner cynicism or opposition to "corporate logic."

From Dent's (1991) cultural viewpoint, the dual structure helped mitigate a direct identity clash – the vets could still see themselves as independent professionals in their day-to-day work, not "cogs following scripts," which was crucial for their acceptance of the new regime. Yet the split also created a kind of split identity: on the ground they were healers with autonomy, but on paper they were employees subject to metrics. This is inherently stressful, and long-term integration would likely require bridging that gap, perhaps by socializing staff gradually into some of the corporate thinking (e.g. explaining why cost control is needed in a way that resonates with their mission) and conversely, socializing corporate managers into the professional values of the clinic (so that, for example, they approach decisions with an understanding of veterinary ethics and client relationships). Essentially, to sustain a healthy centralization/decentralization balance, both sides need to develop mutual understanding. In practice, IVC could have, for instance, publicly acknowledged the value of the autonomy it left intact: telling the clinic "We trust your professional judgment" explicitly, which might have strengthened goodwill. Simultaneously, they should take care that centralized actions (like budget cuts or top-down initiatives) don't inadvertently sabotage the benefits of that autonomy. Bringing clinicians into discussions that affect clinical operations (such as staffing models or service offerings) would ensure that central decisions are informed and that local leaders feel heard, rather than feeling that edicts are just imposed.

Interestingly, the "dual identity" we noted – where staff prided themselves on still doing right by the animals (decentralized realm) but simultaneously felt pressured to meet corporate expectations (centralized realm) – suggests that over time, integration could go in a couple of directions. Optimistically, it could lead to a blended identity: staff might start to see that financial sustainability and clinical care are both important (the ideal "marrying of metrics with mission"). There were hints of this, for example, some managers acknowledging the need for better billing and cost control, which they might not have considered before. Pessimistically, it could also lead to burnout or exit: if employees find the dual demands irreconcilable, they may leave (as some did) or disengage. The outcome likely depends on whether the organization can align those domains by adjusting policies and by cultural communication that reconciles profit and care (e.g., emphasizing that financial health enables better care – a narrative that was missing in IVC's approach). Our study suggests that integrators should proactively craft a unifying narrative or culture that includes both the old and new values, to help employees form a coherent understanding of their role. In absence of that, employees oscillate between competing value systems, which is stressful and unsustainable.

5. Discussion

5.1 Theoretical Contributions

This thesis makes several contributions to the literature on post-acquisition integration, particularly at the intersection of management control systems (MCS) and organizational culture:

Bridging Structural and Cultural Integration Theories: Prior research often examines either the structural/control aspect of integration (e.g., systems, processes, hierarchies – as Busco et al. (2008) and similar works do) or the cultural/identity aspect (e.g., how cultures clash or merge in mergers – as per Dent (1991) and many studies of M&A cultural fit). This study contributes by empirically demonstrating how these two dimensions are deeply intertwined. I show that structural tensions (vertical-lateral, etc.) cannot be fully understood without considering cultural responses. In this case, many of

the difficulties in managing the formal tensions were exacerbated or alleviated by cultural factors (e.g., “us vs them” exacerbated vertical issues; professional ethos alleviated what could have been even worse centralization issues). Thus, this provides support for a more holistic theory of integration: one that simultaneously addresses formal control design and cultural alignment. The integration of Busco et al (2008) and Dent’s (1991) frameworks in our analysis is a novel theoretical approach, and the case results affirm that such an integrated lens yields a richer explanation of outcomes. The thesis therefore contributes by illustrating the value of an integrated structural-cultural perspective in understanding post-acquisition management control changes.

Insight into Managing Integration Tensions: The findings nuance Busco et al.’s (2008) concept of integration tensions by showing the mechanisms by which organizations attempt to manage them and the potential outcomes. An observe natural experiment of sorts: IVC’s initial approach leaned heavily toward one side of each tension (vertical, convergent, centralized) and met resistance, leading to a later state that was more balanced (some lateral elements emerging, local differentiation persisted, partial decentralization). This trajectory suggests that effective integration might often require a period of rebalancing. Theoretically, this contributes the idea that integration is dynamic – tensions may spike and then subside as organizations learn and adjust. Busco et al. (2008) mainly characterized the tensions; we provide empirical evidence of how an organization navigates them over time, including the role of iterative adjustments and informal workarounds. This adds depth to integration theory by highlighting adaptation and learning post-acquisition, not just initial integration strategy.

6. Conclusion

By examining the case through the combined lens of Busco et al.’s (2008) tensions and Dent’s (1991) cultural perspective, the study contributes to a more nuanced understanding of PMS in post-acquisition scenarios. It shows that PMS, conceived as a cohesive package, can negatively affect the culture when tensions are not managed.

6.1 Limitations

This thesis is subject to certain scope delimitations and study limitations. First, the geographic scope is restricted to the United Kingdom, focusing on one corporate veterinary group (IVC) and one equine clinic. This allows for a deep, context-rich analysis but means the findings may not directly generalize to other countries, clinics or cultural settings where both veterinary practices and corporate management styles could differ. Secondly, the study examines the integration at a particular point in time – in the medium term after acquisition. Unlike longitudinal studies such as Carlsson-Wall et al. (2019) or Busco et al. (2008) that tracked changes over multiple years, this thesis does not capture longer-term evolution of controls. For instance, certain tensions that were observed may well dissipate or new tensions might emerge as the organization moves further from initial integration shocks to a steady state of operation. The absence of pre-acquisition interview data also limits my ability to compare employees' perspectives before and after the changes – the analysis relies on retrospective accounts of "how things used to be," which could be colored by nostalgia or selective memory.

Additionally, this case is an in-depth single-case study of one equine clinic within IVC's portfolio. The clinic has unique features (an equine specialty, a 24/7 hospital service, etc.) and IVC's corporate culture (shaped by private equity ownership and rapid growth targets) may not represent all IVC clinics. Finally, as a qualitative study, the data – primarily interviews with clinic staff – capture perceptions and subjective experiences.

Despite these limitations, the chosen scope and methodology provide a way to explore of the research question in great and case-specific depth. The insights should be interpreted within the context of this case, with opportunities identified for future research to test and expand upon them in other settings.

6.2 Directions for Future Research

Building on this thesis, there are several avenues for future research that could deepen and broaden the understanding of post-acquisition management control integration and its relation to not just tensions but cultural integration.

Comparative Case Studies: A fruitful next step would be to study multiple acquisitions – ideally in a comparative design – to see which findings hold across cases and which are context-specific. For example, examining a number of different clinics acquired by the same company (IVC or a similar vet group) could reveal whether the trajectory observed (initial clash, then hybrid adaptation) is typical. Do clinics in other regions or of different specialties experience the same tensions and resolution patterns? Additionally, comparing across industries – say, a veterinary clinic vs. a human healthcare practice vs. an accounting firm acquisition – would highlight how professional identity and industry norms alter the integration process of change management. Such comparative research could validate the notion that professional organizations require a particular integration approach and might refine the framework by identifying additional tensions or factors (e.g., regulatory environment, client involvement) that play a role.

Longitudinal Research: A long-term longitudinal study following an acquired unit over several years would be extremely valuable. This could track the evolution of control systems and culture from pre-merger (if possible) to the post-merger integration period and onward to stabilization. With periodic observations (say at 6 months, 1 year, 3 years, 5 years post-acquisition), researchers could observe whether initial tensions diminish, whether hybrid solutions persist or eventually tilt more towards corporate standardization, and what the long-run outcomes are (in terms of performance, employee retention, etc.). Questions like “Does employee acceptance of new controls increase after, say, 2–3 years?” or “Do initial compromises (like the dual systems) remain, or does one system win out over time?” could be answered. This would address the limitation of snapshot views and contribute to change management theory by illuminating the phases of integration (e.g., an initial crisis, an adjustment period, a normalization period).

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8. Appendix

List of Interviewees

Interview object	Rank (Partner vet, vet, nurse or admin)	Length in min
1	Partner Vet	30
2	Admin	20
3	Admin	20
4	Nurse	18
5	Vet	21
6	Vet	15
7	Admin	25
8	Vet	15
9	Partner Vet	24
10	Partner Vet	31
11	Vet	24

Interview guide

Introductory / Contextual Questions

Could you start by describing your role in this clinic?

How long have you been working here?

Socio-Ideological Controls (e.g., Shared Values, Culture, Beliefs)

How would you describe the culture or values prior to IVC took over as owners? In 3 words? More broadly?

How would you describe the culture or values past to IVC took over as owners?

In 3 words? More broadly?

What changes, if any, have you noticed in the clinic's culture or values since IVC took over?

How have that affected you?

Do you believe it has improved your work performance?

How do managers or leadership communicate the 'desired ways of working' or 'core values' here?

Can you recall a moment where you felt the cultural expectations from IVC influenced how the team collaborates or behaves?

Technocratic Controls (e.g., Performance Management Systems)

Could you describe the performance metrics, reporting systems, or procedures that you used prior to the acquisition?

Could you describe the performance metrics, reporting systems, or procedures that were introduced after the acquisition?

Could you describe the how these performance metrics, reporting systems, or procedures have affected you? And the clinic?

How have these new systems or metrics influenced your day-to-day tasks or decision-making?

In what ways, if any, do you feel these formal controls (PMS, financial targets, standardized protocols) help or hinder your team's effectiveness?

Tensions: Vertical vs. Lateral Relations

How would you describe the relationship between your clinic, IVC's headquarters (vertical), and other IVC clinics (lateral)?

Can you share an example where you collaborated with another clinic or where you needed support from headquarters? How did that go?

Have you experienced any friction or tension between what headquarters expects versus how your clinic prefers to operate?

Tensions: Convergence vs. Differentiation of Practices

Have there been efforts to standardize processes or practices across clinics (e.g., uniform policies, shared protocols)? How has that affected your local operations?

In what areas do you feel the clinic still has the freedom to adapt practices to local needs (e.g., local customer demands, specialized treatments)?

Could you share a situation where there was a conflict or compromise needed between standardized procedures and local preferences?

Tensions: Centralization vs. Decentralization of Decision-Making

How would you describe the current decision-making process regarding budgets, staffing, or clinical protocols?

Are there areas where you feel decisions are now more top-down compared to before the acquisition?

How does the clinic's leadership balance corporate directives with local insights or autonomy?

Interplay Between Technocratic and Socio-Ideological Controls

In your view, how do the formal (technocratic) systems and the cultural/values-based (socio-ideological) elements interact in this clinic?

Have you noticed instances where the new performance metrics influenced team values or vice versa?

How do you feel about the balance between these two types of controls? Would you say they complement each other or create tension?

Reflections and Looking Ahead

What have been the biggest challenges for you personally in adapting to IVC's approach (both formally and culturally)?

What do you think could be improved in terms of supporting employees through these changes?

Is there anything else you would like to add regarding how the acquisition has influenced your work, the clinic's culture, or overall performance?

AI-disclosure detailing:

- What AI tools have been used and how.

Chat GPT primarily to improve and check English from a grammar point of view. Basic questions.

- In what ways have these tools contributed to increasing the quality of the thesis?

English grammar

- What potential risks were found using AI and what measures were taken to reduce these risks?

Check that the improvement in English didn’t change the meaning of the sentence.

- What are the insights gained from using AI tools in the thesis writing process?

Chat GPT is better at English then me.